COMPREHENSIVE PERINATAL SERVICES PROGRAM
COMBINED POST-PARTUM ASSESSMENT

Client Name _____ DOB _____ Delivery Date _____ Date _____

ANTHROPOMETRIC □ WT. GRID PLOTTED
Height _____ Desirable Body Weight: _____
Weight this Visit: _____ Weeks Post-Partum_____
Comment: _____
_____

BIOCHEMICAL
Blood Date Collected: _____
Hemoglobin: H L Hematocrit: H L
Glucose: H L Albumin: H L
Blood Pressure: / (circle) GDM PIH

CLINICAL-Outcome of Pregnancy

Date of Birth: _____ Gestational Age:_____
Birth Weight: _____ Birth Length: _____
Delivery □ Vaginal □ C-section
Pregnancy Outcome/Complications:

Maternal
1. Have you had your post-partum check up? □ Y □ N
   If NO, when is it scheduled? _____
2. Have you had any problems since delivery? □ Y □ N
   If YES, please explain. _____
   _____

Infant
3. Has you baby seen the doctor? □ Y □ N
   If NO, when is the visit scheduled?

NUTRITION
Dietary Assessment □ 24 hour recall completed
4. Are you on a special diet? □ Y □ N
   If YES, what diet? _____
5. Are you allergic to any foods, or do you avoid eating any foods?
   If YES, what foods? _____
6. Which of the following do you take?
   □ Prenatal Vitamins □ Iron Pills
   □ Other Vitamins/Mineral □ Herbs
   □ Antacids □ Laxatives □ Other Medications
7. How many cups, glasses or cans of these do you drink daily?
   Water _____ Milk _____ Juice _____ Coffee ____
   Tea ____ Soda ____ Diet Soda ___ Punch/Kool Aid
8. How many times a day do you usually eat? _____
9 Which of the following do you have?
   □ Refrigerator □ Stove/Oven □ Hot Plate

Infant Feeding
10. How many diapers does your baby wet in a day? _____
11. If you are Breastfeeding:
    a) how many times in 24 hours do you nurse? _____
    b) how long does your baby nurse each time? _____

Infant Feeding (cont.)
12. If you are Bottlefeeding,:
    a. How often does your baby get a bottle? _____
    b. How much does your baby drink at a feeding? _____
    c. √ the one(s) you use: □ Concentrated Formula
       □ Powdered Formula □ Ready to Drink Formula
    d. What else do you give your baby?
       □ Juice □ Cereal □ Sugar Water
       □ Baby Food □ Other _____

HEALTH EDUCATION
13. Do you have any questions about your baby's care? □ Y □ N
    If YES, please explain: _____
    _____
14. Which method of Birth Control are you currently using:
    □ Birth Control Pills □ Diaphragm □ Condoms
    □ Norplant □ Depo-Provera (shots) □ Other _____
15. Would you like information about Birth Control? □ Y □ N
16. Do you have an infant car seat? □ Y □ N
    If YES, do you always use it? _____
17. Do you exercise 3 or more times a week?
18. Do you smoke? □ Y □ N
    If YES, how many cigarettes per day? _____
19. Do you live with someone who smokes ?
20. How often do you drink beer, wine, or liquor? _____
21 What drugs have you used since the birth of your baby?

PSYCHOSOCIAL
22. Since your baby's birth, which of the following have you had?
    □ trouble sleeping □ sadness □ worried feelings
    □ crying □ depression □ other _____
23. If you are worried about something, who do you talk to?
    _____
24. Are you and your baby safe in your home? □ Y □ N
25. Have you ever planned or tried to hurt yourself? □ Y □ N
26. Have you ever planned or tried to hurt someone? □ Y □ N
27. Since the birth of your baby, have you been slapped, hit, kicked or otherwise physically hurt by someone? □ Y □ N
    If YES, by whom? _____
28. Do you have: □ electricity □ hot water □ telephone
    □ transportation □ heating
29. Are you able to buy enough food? □ Y □ N
30. Are you able to pay your rent? □ Y □ N
31. Are you able to pay your other bills? □ Y □ N

□ WIC Referral Date enrolled _____ Appt. Date _____
Other referrals:
1) _____ Date _____
2) _____ Date _____
Material Given: □ Family Planning □ Infant Feeding
□ other _____ □ other _____

Assessment completed by: _____
Time spent in minutes: Nutrition_____
Health Education_____
Psychosocial _____